CITY OF

ALBUQUERQUE

Employer-Sponsored Group Benefits

CONTRACT YEAR
July 1, 2009 - June 30, 2010

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This brochure is intended for summary purposes only. In all cases only the official plan documents control the administration and operation of the plans. Please be aware that some of the benefits listed in the various tables have limitations. See your Summary Plan Description (SPD) for more details. This brochure does not constitute a contract of employment nor does it change your employment-at-will status.

Your employer retains the right to modify benefits or premiums during annual contract negotiations to obtain benefits for employees.

CITY OF ALBUQUERQUE

MARTIN J. CHAVEZ, MAYOR

Dear Fellow Employees:

The City of Albuquerque is proud to continue providing one of the most comprehensive and reasonably priced packages of benefit offerings available in New Mexico. We are also pleased with the launch of our Employee Wellness Program, which has made great progress in keeping our City fit, and was awarded the *Start! Fit Friendly Companies Gold Award* from the American Heart Association. During the past year over 2,000 employees and family members participated in various wellness initiatives such as the *Changes That Last a Lifetime* and the *10,000 Steps* programs. Employees who participated in the wellness programs had an average weight loss of 8.9 pounds per person, and at-risk blood pressure readings were improved by 76%!

Healthy lifestyle choices not only impact our individual and family health status, they have a very direct impact on the cost we all pay for group health benefits. Please join me and all department leaders in actively participating in the variety of health and wellness activities provided by our Employee Wellness Program. You'll be surprised at how much fun you can have and you'll feel better, too!

I also want to encourage everyone to seriously consider participating in one of our Flexible Spending Accounts (FSA). If you have out of pocket expenses for child or dependent care, medical supplies, eyeglasses, prescriptions or even parking expenses, you could be saving money by participating in our FSA program. Three separate accounts are available for Medical Expenses, Dependent Care, or Parking/Transit Expenses. Enrollment in this program increased by over 30% last year, and continues to grow as more employees discover how it can actually increase take home pay by using pre-tax dollars to cover out of pocket expenses. I encourage you to talk to our Insurance & Benefits staff about how an FSA might help you, or ask someone you know how it's working for them.

Please take a moment to review this handbook and please keep it close by as a quick reference guide to your benefit program. With the wide variety of benefit offerings available, it is important to take some time to review the choices and options with your family. For additional information regarding the benefit program, I encourage you and your family members to attend one of the many enrollment meetings scheduled around the City from May 18 through June 12. If at any time you have questions about your Group Health Benefit Program, please contact the Insurance and Benefits Division of the Human Resources Department at (505) 768-3758.

Best Wishes,

Martin J. Chavez, Mayor

Rules and Regulations – Guidelines for Enrollment

These rules and regulations apply to employees of the City of Albuquerque and government entities that have elected to participate in the same insurance plans. There may be differences in eligibility between entities. For example, not all governing bodies of the entities have approved allowing an employee's domestic partner and his/her children to be eligible for insurance coverage. Entities also differ in the employer contribution towards insurance premiums. Please check with your employer's Benefits Office for clarification.

Who is Eligible

- Eligible people are:
- Permanent employees (including those on probation)
- Elected officials
- Unclassified employees scheduled to work 20 hours or more each week
- Legal spouse of an employee
- Domestic partner of an employee*****
- Children that are financially dependent on the employee, unmarried and under age 25 AND meet at least one of the following criteria:
    - Natural child of the employee, spouse or domestic partner
    - Placed in the employee's home and in process for being adopted by the employee, spouse or domestic partner
    - Adopted by the employee, spouse or domestic partner
    - Court order that requires the employee, spouse or domestic partner provide medical insurance coverage for the child
    - Court document that shows the employee, spouse or domestic partner has full, permanent custody of the child
    - Children over age 25 may **continue** participating in the group insurance plans if they are physically or mentally handicapped and are not eligible for any other plan. This continuation is subject to normal enrollment guidelines and approval by the insurance carrier.

***** A domestic partner is defined as a person of the same or opposite sex who lives with the employee in a long-term relationship of indefinite duration. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child meets the definition of eligibility state above. Note the criteria and required documents in the *Changing Benefit Elections* section.

Benefit Options

Options may vary by participating entity but usually include:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Life Insurance
- Long Term Disability Insurance
- Flexible Spending Accounts (Medical, Dependent Care, Parking/Transit)

Coverage Options

- Employee Only
- Employee Plus Spouse or Domestic Partner
- Single Parent
- Family

Changing Benefit Elections and Qualifying Events

Many of the rules for enrollment and eligibility are made by the Internal Revenue Service because they allow your salary to be reduced by the premiums you pay before taxes are calculated (Internal Revenue Code Section 125.) Important rules to know are:

Once you have made an election during your initial enrollment period of 31 days from your hire date then you are **locked into that decision until the next open enrollment.**
Exceptions to this are qualifying events due to a life status change. You must provide documentation of the life status change and complete forms within **31 days of the qualifying event**. Qualifying events and acceptable documents are:

- **Marriage** - Marriage certificate
- **Domestic Partnership meeting eligibility requirements** – Affidavit*
- **Divorce** – Court issued divorce decree
- **Birth** – Hospital certificate or state issued birth certificate
- **Death** – Death certificate
- **Change in employment** status affecting benefits eligibility (for you or your spouse) - Letter/form from employer that is notification of the job change, coverage ending or new eligibility
- **Open Enrollment** period of Spouse/Domestic Partner's employer
- **Involuntary loss of coverage** – Official notification of loss
- **Dependent child losing eligibility** - Official notification of loss
- **Dependent change of residence** that affects benefits eligibility - Notification of change
- Dental Insurance Only – **dependent child between the ages of 2 and 3** may be added to a plan in which the employee is already enrolled

* The **Affidavit of Domestic Partnership** is a legal document in which both the employee and the domestic partner swear that they meet the following criteria:

- Both are unmarried
- Reside in the same residence for at least 12 months and intend to do so indefinitely
- Meet the age requirements for marriage in the state of New Mexico
- Are not related by blood to the degree prohibited in a legal marriage in the State of New Mexico
- Are financially responsible for each other's welfare and share financial obligations

In addition to the notarized affidavit, **three** of the following documents are also required.

- Joint lease/mortgage or ownership of property
- Jointly owned motor vehicle, bank or credit account (only one qualifies)
- Domestic partner named as beneficiary of the employee's life insurance
- Domestic partner named as beneficiary of the employee's retirement benefits
- Domestic partner named as primary beneficiary in the employee's will
- Domestic partner assigned as power of attorney or legal designee by the employee
- Both names on a utility bill
- Both names on an investment account

The employee's domestic partner is not required to visit the Insurance & Benefits Office in order to receive benefits. The employee may bring the signed and notarized Affidavit of Domestic Partnership with the other required documents.

The Federal Government does not recognize domestic partners as qualified dependents and therefore the premium paid for their coverage cannot be pre-tax. In addition, the employee must pay tax on the portion of the premium paid by the city for the domestic partner and his/her covered children. Employees wanting to change benefit elections involving a domestic partner must adhere to the same rules regarding qualifying events.

Missing the initial enrollment period, 31-day qualifying event period or the annual open enrollment period, may result in **delayed enrollment**, a delay in notification of loss of coverage and **paying for coverage no longer provided**.
The effective date will depend on the event and when documents and forms are submitted to your employer (see below.)

Name/Address Changes: It is important to keep your employer and the insurance plans informed when you experience a name and/or address change to prevent a disruption of service and receipt of important policy information. Please visit the Human Resources Office to complete forms which will be forwarded to the proper carriers.

Effective Date of Coverage, Changes and/or Terminations

New employees – Coverage begins on the first day of the current pay period if forms are completed and required documents are brought to New Employee Orientation (NEO) or submitted to the Insurance & Benefits Office by the end of the first week. Pay periods begin on Saturday and are two weeks long. Paychecks are issued on the Friday following the end of the pay period. NEO is usually held on Monday following the beginning of a pay period. You have 31 days from your hire date to submit completed forms and verification of dependent eligibility. If not on the hire date then coverage will begin on the first day of the pay period following the submission of completed forms and verification of dependent eligibility.

Qualifying Events – Coverage begins on the first day of the pay period following the submission of completed forms, verification of dependent eligibility and documentation of the qualifying event as long as the forms and documents are received in the Insurance and Benefits Office within 31 days from the event. The only exception to this is when the event is the birth of a child. The coverage begins on the date of birth if documentation and forms are completed and submitted to the Insurance & Benefits Office within the 31-day enrollment period.

Open Enrollment – Benefit changes elected during open enrollment are effective on July 1st or June 30th for coverage ending.

Termination of Coverage

Insurance ends at the end of the pay period in which the event occurs. Exceptions to this are the termination of coverage due to retirement and a dependent child losing eligibility under the plan. In these cases, coverage ends at the end of the month in which the event occurs.

Open Enrollment

This is a three week (or longer) period established annually (usually in May) that allows all benefits eligible employees to make changes to their benefit elections without having experienced a qualifying life status change. It is the only opportunity to switch plans. Annual premium changes also occur at this time and will automatically be updated on your first paycheck in July without you having to make a new election.

Insurance Premium and Benefit Plan Participation Payments

The insurance premiums listed in this booklet are stated as biweekly amounts. They reflect 17% of the full premium. The city pays 83% of medical, dental and vision premiums regardless of the coverage options you elect. The benefit payments are deducted for coverage during the same two week period for which you are paid. Your earnings are reduced by your portion of the medical, dental and vision insurance premiums before Federal, State and FICA taxes are calculated, thereby saving you money.

Employees are responsible for paying their Group Health Premiums regardless of receiving a paycheck. This means if your employment status is "active" and you do not receive a paycheck then you will be responsible for paying the employee AND the employer portion of your medical, dental, vision premiums, and also your current deduction(s) for other supplemental benefits in that period. You will be responsible for making payment arrangements through the Insurance and Benefits Office (contact information is provided in the back of this booklet). Payment arrangements depend on the situation and will be looked at on an individual basis. Failure to either make payment arrangements or to make timely payments will result in cancellation of benefits to the last pay period in which the premiums were paid.

NOTE: You are exempt from having to pay the employer's portion if you are on military leave or approved leave under The Family Medical Leave Act.

COBRA

The Comprehensive Omnibus Budget Reconciliation Act (COBRA) is the federal law that allows the employer to offer continued participation in medical, dental, and/or vision group insurance coverage if your employment terminates (18 months maximum) or your covered dependent loses eligibility (36 months maximum.) Domestic partners of employees are not eligible to continue coverage under COBRA when their eligibility ends under the active employee plans. Electing to continue coverage must be made within 60 days of the date eligibility was lost on the active employee plans. The cost of the coverage is 102% of the full monthly premium. You will receive written notification of your rights and responsibilities when you or your dependent experience an event that qualifies. Additional information is available in the Insurance and Benefits Office.

Your Employee Wellness Program

The City of Albuquerque, in partnership with BlueCross BlueShield of New Mexico and Presbyterian Health Plan, is committed to focusing more on you and your health in 2009 and beyond. We are proud to offer a comprehensive wellness program for all City employees and dependents. If you're looking to lose weight, stop smoking or just learn more about keeping your family healthy, we have services and resources in place to help you every step of the way.

Your Employee Wellness Program is designed to:

- Help provide a healthful work environment
- Support the adoption of healthy habits to improve individual health and fitness levels
- Provide increased knowledge of and access to health promotion, health education, disease reduction and other programs and resources to benefit employee well-being

We are pleased to offer the following Wellness benefits:

- Comprehensive health screenings **offered at no charge** to enable employees easy and convenient access to important measurements and education

- A series of wellness seminars on topics such as: smoking cessation, weight management, and stress management

- A monthly wellness newsletter filled with information, inspiration, and motivation

- Employee and family Wellness Fairs featuring access to a wide array of vendors and partners

- Accurate, up-to-date health information on both our City Employee Website and Gov TV channel

Help make this effort an even greater success! For more information, to submit your story of healthful living, or to become a "Wellness Champion" for your department, please contact **JD Maes, your wellness coordinator, at 768-2921 or jmaes@cabq.gov.**

How can you improve your health in just 15-20 minutes?

Complete the online Health Risk Assessment (HRA) and get connected to a healthier way of life. The confidential HRA will assess your current lifestyle choices and personal & family health history to provide immediate personalized feedback. This customized report is only available if you are participating in a City sponsored medical insurance program, and will give you tools to improve or maintain your family's health. Complete your HRA by July 1, 2010 to receive a **$25 gift certificate to Subway ®.** Log on today!

For BlueCross BlueShield members:

- Go to www.bcbsnm.com
- Register for Blue Access for Members
- Select Personal Health Manager
- Select "Take Your Health Risk Assessment"
- Complete the questionnaire

For Presbyterian Health Plan Members:

- Go to www.phs.org
- Select "Login to Pres Online or Register"
- Select "WebMD Health Manager (HRA)"
- Select "Health Risk Assessment"
- Click on "Take Health Risk Assessment Now"

Additional Benefits of Completion:

- Access to tools and programs based on your areas of personal health risk
- Information on improving your health and well being with a focus on what's a priority to *you*
- Knowledge of choices you're making that actually protect your health
- Steps you can take to get the most from your doctor visits and health plan benefits

City of Albuquerque
Biweekly Insurance Rates FY2010
July 1, 2009 - June 30, 2010

Medical Insurance - Employee pays 17% Employer pays 83%

Presbyterian My Care Health Plan	Employee*	City	Total
Single	27.25	133.02	160.27
Couple	55.44	270.67	326.11
S/Parent	43.77	213.69	257.46
Family	80.01	390.62	470.63

Blue Cross and Blue Shield of New Mexico	Employee*	City	Total
Single	24.76	120.91	145.67
Couple	47.78	233.26	281.04
S/Parent	43.17	210.79	253.96
Family	70.79	345.61	416.40

Dental Insurance - Employee pays 17% Employer pays 83%

Delta Dental	Employee*	City	Total
Single	2.36	11.51	13.87
Couple	4.71	23.01	27.72
S/Parent	4.89	23.89	28.78
Family	6.59	32.18	38.77

United Concordia Dental	Employee*	City	Total
Single	2.27	11.10	13.37
Couple	4.86	23.73	28.59
S/Parent	5.02	24.52	29.54
Family	6.77	33.07	39.84

Vision Insurance - Employee pays 17% Employer pays 83%

Davis Vision	Employee*	City	Total
Single	0.39	1.92	2.31
Couple	0.74	3.62	4.36
S/Parent	0.79	3.83	4.62
Family	1.18	5.75	6.93

Long-Term Disability Insurance (voluntary)

CIGNA	Biweekly
Age	Rate per $1 of BW Salary
<30	0.00262
30-39	0.00406
40-44	0.00536
45-49	0.00770
50-54	0.01004
55-59	0.01199
60>	0.01238

Flexible Spending Account (voluntary)

BASIC (medical, dependent care, parking or transit fee)	$4.50 City Paid Monthly

* Biweekly = monthly times 12 divided by 26

Basic Life and AD&D

CIGNA (100% Paid by City $.32 per $1,000)	
Amount of coverage is 140% of gross annual salary	
Minimum	Maximum
$25,000	$50,000

Supplemental Term Life (voluntary)

CIGNA Biweekly Rates Per $10,000		
Age	Smoker	Non Smoker
<30	0.443	0.215
30-34	0.550	0.275
35-39	0.882	0.443
40-44	1.218	0.658
45-49	2.258	1.271
50-54	3.381	1.880
55-59	4.925	2.709
60-64	6.248	3.486
65-69	9.230	5.198
70-74	17.577	9.786
75-79*	27.290	15.194
80 +	65.573	36.572
*Spouse age limit is 75		

CIGNA Dependent Child Term Life	
Coverage	Rate
$2,500	0.240
$5,000	0.480
$7,500	0.720
$10,000	0.960

Medical Plans

Plan Benefits

Each of the medical plan options provides comprehensive medical coverage for enrolled members. On the next pages you will find a general description of each of the plans, followed by a Benefits-At-A-Glance chart comparing key benefits of both plans. Finally, you will see a list of exclusions for items that neither of the plans cover.

In order to choose the plan that is right for you and your family, review the benefit levels for each plan, as well as the medical providers available to you.

Keep in mind this information is a summary only, and you should refer to each plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choices

You have the option to choose between two medical plans:

- Presbyterian Health Plan My Care Plan
- Blue Cross and Blue Shield of New Mexico

Cost of Coverage

No matter which plan you choose, your employer will pay a portion of the premium. The chart below shows your portion of the cost, which is taken on a per pay period basis. As you can see, your cost depends on the plan you choose as well as what family members you enroll.

	Bi-Weekly (26 Pay Periods) Contributions			
	Presbyterian My Care Plan		BCBSNM	
	Employee	Employer	Employee	Employer
Employee only	$27.25	$133.02	$24.76	$120.91
Employee and spouse	$55.44	$270.67	$47.78	$233.26
Employee and children	$43.77	$213.69	$43.17	$210.79
Employee and family	$80.01	$390.62	$70.79	$345.61

Blue Cross and Blue Shield of New Mexico

Offering a PPO health care plan to the employees of the City of Albuquerque and Participating Entities – a plan that includes the most comprehensive provider network in New Mexico; the unique BlueCard program that gives you access to doctors nationwide; a comprehensive wellness program with tools available to you and your family; and customer service based in Albuquerque: we strive to meet our customers' needs with every interaction – more than nine times out of ten, inquiries are resolved during the first phone call.

Benefits include preferred primary provider visits for a $15 copay and preferred specialist visits for a $25 copay – with no deductible. You receive comprehensive prescription drug benefits, including mail-order and specialty medicine programs. Please see the summary of benefits included in this booklet.

Provider Choice and Access

- **The most comprehensive provider network** of any health plan doing business in New Mexico, with over 11,000 PPO providers statewide, including 12 hospitals in the greater Albuquerque area and all the regional hospitals outside the Albuquerque area. Our network includes the only women's hospital in the state and the Heart Hospital.
- **National and worldwide network** through the BlueCard® Program. BCBSNM members are covered at in-network benefit levels throughout the United States and in over 185 countries. Approximately 80 percent of physicians and 90 percent of hospitals nationwide participate with a Blue Cross and Blue Shield Plan.
- **Freedom to choose out-of-network providers**, and pay a percentage of eligible charges.

Concierge Customer Service

Our Albuquerque-based Customer Advocates are trained to anticipate your health and customer service needs. Concierge service means we will provide you with the personalized and individualized service you deserve. Our Customer Advocates treat each member inquiry as an opportunity to interact with the "whole person" and not simply respond to the immediate question.

Experience. Wellness. Everywhere.[SM]

Blue Access® for Members – your online resource (bcbsnm.com)

- Check claims status and view explanation of benefits (EOBs) online
- BCBSNM Provider Finder®
- Hospital Comparison Tool
- BCBSNM Drug List
- Treatment Cost Advisor™

Personal Health Manager (PHM)

- Manage your personal and family health with confidence at **bcbsnm.com**
- Complete a confidential general Health Risk Assessment (HRA), and choose among five additional optional HRAs: sleep, stress, nutrition, physical activity, and musculoskeletal health
- Prepare for a doctor's visit or medical procedure
- Ask health-related questions from registered nurses, dieticians, and licensed personal trainers through our online *Ask-a-* features
- Use the Interactive Symptom Checker
- Manage your weight or quit smoking using our weight management and smoking cessation tools
- Research health information with the Healthwise® Knowledgebase

Check out a demo of Blue Access for Members and PHM:

- Go to bsbsnm.com.
- Enter the User ID: **demo** and the Password: **bam1demo1** in the BAM login box.
- On the Select *Member Criteria* screen, select a *Product* (e.g., PPO) and check *Personal Health Manager* listed under *Other Products*.

This brings you to our secure member portal. To see the Personal Health Manager, select the *Personal Health Manager* link to access the demo.

BlueExtras Discount Program℠

Receive discounts on health care products and services not usually covered by health care benefit plans, including:

- Jenny Craig® and Curves® memberships
- Digital hearing aids through TruHearing®
- Eyeglass frames and lenses, contact lenses, laser vision correction, exams, and accessories through Davis Vision®
- Complementary Alternative Medicine, including a variety of health-promoting therapies, vitamins, herbal supplements, health and wellness magazines

Blues Healthline

Receive the award-winning quarterly member newsletter, *Blues Healthline*, with provider network and drug updates, the latest news in healthy lifestyle choices, and wellness and disease management tips.

Blue Points℠

Track a fitness workout, report a healthy meal, or use other *For Your Health* features on **bcbsnm.com** to earn Blue Points. Blue Points are redeemable at the online Blue Points Redemption Center for health promotion products and gift cards to stores and restaurants.

And More...

Disease Management programs are available at no additional charge and address conditions such as:

- Asthma
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Diabetes
- Gastroesophageal reflux disease
- Hypertension
- Low back pain
- Migraine
- Obesity

Blue Care Advisors (BCAs) are registered nurses who help members with chronic conditions develop a plan of care and prioritize goals and objectives. BCAs will provide member education and support, assess gaps-in-care and barriers to accessing care, act as a patient advocate, and assist the member to set and reach realistic health goals over a period of time.

24/7 Nurseline nurses offer triage services, discuss appropriate care, and provide information to help you with your health decision-making processes. You can also call the 24/7 Nurseline to access an audio library of more than 1,000 health care topics; 600 of these are also available in Spanish.

Special Beginnings® offers additional prenatal support, supplemental to a doctor's care, and includes online tools and educational materials that are customized to meet the specific needs of mom and baby.

For more information about this plan, call us at 1-877-232-5538

My Care

One plan, three benefit options

With Presbyterian Health Plan's My Care Plan, employees can choose among three different benefit options to find a plan that best fits their unique needs: the Active, Family, and Independent options.

Once you select an option, you and your qualifying dependents will remain in that option until the next open enrollment. Each option is priced the same, and your per pay period contribution is the same for all options. The benefit levels vary as outlined below.

The Active Option

The Active option is a good fit for individuals, couples, or some families who do not seek medical services often and are mainly concerned with preventive care. The Active option allows you to seek medical services from participating providers and offers a $150 reimbursement per family per contract year under the Unique Services Reimbursement Program for the following:

- Preventive care copays
- Gym memberships*
- Weight loss programs*
- Routine vision care
- Ambulance copays
- Copays for X-rays
- Sterilization services
- Smoking cessation
- Birth control pills
- LASIK surgery
- Vitamins*
- Dental treatment*

The Family Option

The Family option is great for those employees with a family-oriented lifestyle. These individuals typically have young children or are expecting to start a family. Instead of offering a Unique Service Reimbursement Program, this option offers significantly lower copayments for the services that children use most. Well-child care and preventive physical exams are only $5 for children enrolled on this plan and office visits are $10 for children.

The Independent Option

The Independent option is designed for individuals, couples, or families who want to visit doctors outside the Presbyterian network and receive coverage for those costs. This plan offers enhanced out-of-network coverage, allowing you to visit providers outside of the Presbyterian Health Plan provider network. This option offers a $250 reimbursement per family per contract year under the Unique Services Reimbursement Program for the following:

- Preventive care copays
- Prescription drug costs with a physician's prescription
- Routine vision care
- Alternative therapies
- Disease management classes*
- Dental treatments*
- Diagnostic devices*
- Hearing aids

* If recommended by a physician to treat a specific medical condition. A note or prescription from the provider and the Unique Services Reimbursement Form must be submitted.

- Three coverage options designed to accommodate different lifestyles
- Two options offer special reimbursements
- You don't need to select a Primary Care Physician (PCP) under any option

Remember…

Preventive care copays are eligible for reimbursement under your Unique Services Reimbursement Program. See your plan booklet for limitations and filing instructions.

For more information about services and benefits, call Member Services at (505) 923-5678 or 1-800-356-2219 between the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday.

Feel better.
Stay healthy.
Live well.

Providing health care to New Mexico for nearly a century, Presbyterian is uniquely woven into the fabric of this state. Being community owned, we are dedicated to improving the health of individuals, families and communities and will be here when you need us. As an active partner with the City of Albuquerque, we provide employees with the tools they need to feel better, stay healthy and live well.

Feel better.

Pres e-Care
Pres e-Care allows members who have an established relationship with a participating provider to communicate about non-urgent symptoms through a webVisit® for a $5 copay. There is no charge for routine communications, such as appointment requests, lab results, and prescription refills. Visit www.phs.org/e-care for more information.

Nurse Advice Line 1-866-221-9679
Registered nurses are available 24 hours, 7 days a week to answer questions about specific health problems and to provide assistance with self-care of minor illnesses or injuries.

Stay healthy.

Healthy Advantage Wellness Program
Together, the City of Albuquerque and Presbyterian offer an interactive wellness program to help you improve and maintain your health and well-being. Through health risk assessments, onsite screenings, flu-shot clinics, health fairs, and more, members can follow the steps to healthier living.

Selecting a Physician
Another good way to stay healthy is to become established with a practitioner who can serve as a partner for good health and can help you make the best decisions about your overall medical care. You may locate a practitioner with our convenient, online directory at www.phs.org/directory or call Member Services at (505) 923-5678 or 1-800-356-2219 between the hours of 8:00 a.m. to 5:00 p.m., Monday through Friday.

Live well.

Value Added Discounts
Presbyterian members receive valuable discounts for acupuncture, chiropractic care, massage therapy, hearing hardware, vision services, and more through participating BenefitSource providers.

Smoking Cessation Program
If you'd like to quit smoking or using tobacco products, call the Tobacco Quit Line, 1-888-840-5445, for confidential support at no additional cost.

ADAM
Members with a medical question can visit ADAM, a free website offering a wealth of trustworthy health information, anytime via a link at www.phs.org. ADAM also provides useful wellness tools to help you estimate your healthy body weight, target heart rate, amount of body fat and more.

Medical Benefits At-A-Glance

The following is only a summary, some benefits may have further limitations or exclusions.

	Blue Cross and Blue Shield PPO Plan		Presbyterian My Care
			Active
	In-Network	**Out of Network**	
Annual deductible	None	$1,000 ind. $2,000 family	None
Annual out-of-pocket costs	$1,500 individual, $3,000 family	$3,000 ind. $6,000 family	2x your annual premium
Lifetime maximum	Unlimited		Unlimited
Physician services			
Office visit	$15 copay per visit	50% after plan deductible[3]	$20 copay per visit
Specialist visit	$25 copay per visit		$30 copay per visit
Allergy testing	$25 copay per visit	50% after plan deductible	You pay 20%
Injections	$25 copay per visit, $15 copay if PCP	50% after plan deductible[3]	Included in office visit copay
Infertility services	$25 copay per visit, $15 copay if PCP	50% after plan deductible[3]	You pay 50%
Gynecological exam	$25 copay per visit, $15 copay if PCP	50% after plan deductible[3]	$20 copay
Pre and post natal care	$25 copay per initial visit, no charge for all other routine visits	50% after plan deductible[3]	$20 copay per visit up to $200 per pregnancy
Diagnostic X-ray			
MRI	$75 copay[1]	50% after $150 per procedure deductible and plan deductible[1 3]	$125 copay per test
Cat Scans	$75 copay[1]	50% after plan deductible[1 3]	$75 copay per test
Cardiac Cath	$150 copay[1]	50% after plan deductible[1 3]	$200 copay per test
X-Ray and Laboratory	No charge	50% after plan deductible[3]	No charge
Urgent care	$25 copay urgent, $15 copay non appointment care	50% after plan deductible[3]	Participating provider: $25 copay Non-participating provider: $50 copay
Emergency room	$75 copay,waived if admitted	50% after plan deductible[3]	$75 copay per visit, waived if admitted
Ambulance	No charge	50% after plan deductible[3]	$50 copay (ground), $100 copay (air)
Hospital			
Inpatient	$250 copay per admission[1]	50% after $500 per admit deductible and plan deductible[1 3]	$150 copay per day up to $450 per admission[1]
Outpatient	$150 copay[1]	50% after $250 per admit deductible and plan deductible[1 3]	$150 copay per visit[1]
Speech, physical, occupational therapy Outpatient	$25 copay per visit (60 visits per calendar year combined includes acupuncture)[1]	50% after plan deductible[1 3]	$30 copay per visit[1] (2 months per condition)
Acupuncture	See speech therapy	50% after plan deductible[3]	$30 copay per visit (20 visits per calendar year, medical necessity)
Durable medical equipment	No charge (up to $1,000 per calendar year)*[1]	50% after plan deductible[1 3]	You pay 50%[1]
Chiropractic	See speech therapy	50% after plan deductible[1 3]	$30 copay per visit (18 visits per calendar year, medical necessity)
Home Health Care	No charge (100 visits max per calendar year)*[1]	50% after plan deductible[1 3]	No charge[1]
Hospice	No charge[1]	50% after plan deductible[1 3]	$150 copay per day up to $450 per admission[1]
Skilled nursing care	No charge (60 days per calendar year)*[1]	50% after plan deductible[1 3]	$150 copay per day up to $450 per admission (60 days per calendar year) [1]
Dialysis	$150 copay per admission	50% after plan deductible[1 3]	You pay 20% per visit
Mental Health			
Inpatient	$250 copay per admission[1]	50% after $500 per admit deductible and plan deductible[1 3]	$150 copay per day up to $450 per admission[1]
Outpatient	$25 copay per visit	50% after plan deductible[3]	$30 copay per visit[1]
Substance Abuse			
Inpatient	$50 copay per day (30-day max per calendar year)*[1]	50% after $50 per day deductible and plan deductible[1 3]	Detox: $150 copay per day up to $450 per admission[1,3*] Rehab: 25% copay per admission[1,3*]
Outpatient	$25 copay for first 2 visits, $25 thereafter (20 visit max per calendar year)*	50% after plan deductible[3]	$30 copay per visit[1] (30 visits per calendar year)
Prescription drugs			
Retail	Generic $10, brand $35, non-preferred or brand name with generic equivalent 50%	Must be purchased from a participating retail pharmacy	Generic $10, brand $35, non-preferred $55 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, $10 plus difference in cost
Mail Order	Generic $20, brand $70, non-preferred or brand name with generic equivalent 50%	Must be purchased from a participating retail pharmacy	Generic $20, brand $87.50, non-preferred $165 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand, $20 plus difference in cost

[1] Prior authorization/benefit certification applies.

[3] In-network Providers will not charge you the difference between the covered charge and the billed charge for covered services; Out of Network Providers may charge you the difference.

For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Presbyterian My Care		
Family	**Independent**	
	Network	**Out-of-Network**
None	None	$500 individual, $1,500 family
2x your annual premium	2x your annual premium	$6,000 individual, $18,000 family
Unlimited	Unlimited	$2 million
$25 copay (adult), $10 copay (child)	$25 copay per visit	You pay 40%
$35 copay (adult), $20 copay (child)	$35 copay per visit	You pay 40%
You pay 20%	You pay 20%	You pay 40%
Included in office visit copay	Included in office visit copay	You pay 40%
You pay 50%	You pay 50%	Not covered
$25 copay (adult), $10 copay (child)	$25 copay	You pay 40%
$25 copay per visit up to $250 per pregnancy	$25 copay per visit up to $250 per pregnancy	You pay 40%
$200 copay per test (adult) $100 copay per test (child)	$125 copay per test	You pay 40%[1,4]
$125 copay per test (adult) $75 copay per test (child)	$75 copay per test	You pay 40%[1,4]
$300 copay per test (adult) $175 copay per test (child)	$200 copay per test	You pay 40%[1,4]
No charge	No charge	You pay 40%[1,4]
Participating provider: $35 copay (adult), $20 copay (child), Non-participating provider: $45 (adult), $30 copay (child)	$35 copay	$45 copay no deductible
$75 copay per visit, waived if admitted	$75 copay per visit, waived if admitted	$75 copay per visit no deductible
$50 copay (ground), $100 copay (air)	$50 copay (ground), $100 copay (air)	$50 copay (ground), $100 copay (air)
$150 copay per day up to $450 per admission (adult)[1] $100 copay per day up to $300 per admission (child)[1]	$150 copay per day up to $450 per admission[1]	You pay 40%[1, 4]
$200 copay per visit (adult), $100 copay per visit (child)[1]	$125 copay per visit[1]	You pay 40%[1, 4]
$35 copay per visit (adult), $20 copay per visit (child) (2 months per condition)	$35 copay per visit (2 months per condition)	You pay 40%[1, 4] (2 months per condition) Speech therapy not covered out-of-network
$35 copay (adult), $20 copay (child); (20 visits per calendar year, medical necessity)	$35 copay per visit (20 visits per calendar year, medical necessity)	You pay 40%
You pay 50%[1]	You pay 50%[1]	You pay 50%[1,4]
$35 copay (adult), $20 copay (child) (18 visits per calendar year, medical necessity)	$35 copay per visit (18 visits per calendar year, medical necessity)	You pay 40%
No charge[1]	No charge[1]	You pay 40%[1,4]
$150 copay per day up to $450 per admission (adult) $100 copay per day up to $300 per admission (child)[1]	$150 copay per day up to $450 per admission[1]	You pay 40%[1,4]
$150 copay per day up to $450 per admission (adult) $100 copay per day up to $300 per admission (child) (60 days per calendar year) [1]	$150 copay per day up to $450 per admission[1]	You pay 40%[1,4]
You pay 20% per visit	You pay 20% per visit	You pay 40%
$150 copay per day up to $450 per admission (adult)[1] $100 copay per day up to $300 per admission (child)[1]	$150 copay per day up to $450 per admission[1]	You pay 40%[1,4]
$35 copay (adult), $20 copay (child) per visit[1]	$35 copay per visit[1]	You pay 40%[1,4]
Detox: $150 copay per day up to $450 per admission (adult)[1]; $100 copay per day up to $300 per admission (child)[1]; Rehab: 25% copay per admission[1]*	Detox: $150 copay per day up to $450 per admission[1]; Rehab: 25% copay per admission[1,4] *	You pay 40%[1,4]
$35 copay per visit (adult)[1]; $20 copay per visit (child)[1] (30 visits per calendar year)	$35 copay per visit[1] (30 visits per calendar year)	You pay 40%[1,4]
Generic $10, brand $30, non-preferred $50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $10 plus difference in cost	Generic $10, brand $30, non-preferred $50 (30 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $10 plus difference in cost	Not covered unless an emergency outside service area (deductible doesn't apply)
Generic $20, brand $75, non-preferred $150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $20 plus difference in cost	Generic $20, brand $75, non-preferred $150 (90 days up to the maximum dosing recommended by the manufacturer) When generic available but chooses brand $20 plus difference in cost	Not covered

[4] A 15% penalty applies if benefit certification is not obtained.
* 20 visits and 1 episode per calendar year, 3 episodes per lifetime.

[5] Group subscriber agreement supercedes Medical Benefits At-A-Glance chart.

Exclusions to Coverage for the Medical Plans

The following exclusions and limitations apply to both the BCBSNM and the Presbyterian Health Plan My Care medical plans. Items with a "*" may be eligible for reimbursements under the Presbyterian Health Plan Unique Services Reimbursement Program (See page 10 for a summary)

Any exclusion listed would not be applicable if Covered under FIT Program in accordance with that which is required under N.M.S.A.§ 59A-46-38.1. Refer to your Group Subscriber Agreement for details.

- Alternative/complementary therapies, except as specified in the Group Subscriber Agreement (GSA)*
- Any service, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be not medically necessary or accepted medical practice
- Artificial aids including speech synthesis devices except items identified in the Group Subscriber Agreement (GSA)
- Athletic trainers*
- Autopsies and/or transportation costs for deceased Members
- Baby food (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings
- Benefits and services not specified as covered
- Biofeedback, except as specified in the Group Subscriber Agreement (GSA)
- Cancer Clinical Trials are limited to phase 2, 3 and 4 and must be provided for in the State of New Mexico in accordance with the provisions set forth in the Group Subscriber Agreement (GSA)
- Care for conditions which State or local law requires be treated in a public or correctional facility
- Care for military service connected disabilities to which the member is legally entitled and for which facilities are reasonably available to the member
- Charges that are determined to be unreasonable by the carrier
- Circumcisions performed other than during the newborn's hospital stay unless medically necessary
- Clothing or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not
- Co-dependency treatment
- Convenience items
- Cosmetic surgery, treatments, devices, orthotics, and medications, including treatment of hair-loss
- Costs for extended warranties and premiums for other insurance coverage
- Counseling - sex, pastoral/spiritual, and bereavement counseling
- Court ordered evaluation or treatment, or treatment that is a condition of parole or probation or in lieu of sentencing, such as alcohol or substance abuse programs and/or psychiatric evaluation or therapy
- Covered services obtained from a non-participating provider/practitioner, except as provided in the Group Subscriber Agreement (GSA) (Not applicable to the Presbyterian Independent option or to the services eligible for reimbursement under the Unique Services Reimbursement Program services)
- Custodial or domiciliary care - including but not limited to eating, bathing, dressing or other self care activities or homemaker services.
- Dental care and dental x-rays, except as provided in the Group Subscriber Agreement (GSA)*
- Dental implants*
- Disposable medical supplies, except when provided in a hospital or a physician's office or by a home health professional
- Donor sperm
- Exclusions related to covered durable medical equipment - additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty
- Elastic support hose
- Elective abortions after the 24th week of pregnancy
- Elective Home Birth and any prenatal or postpartum services connected with an elective home birth
- Emergency facility used for non-emergent services
- Exercise equipment and videos, personal trainers, club memberships and weight reduction programs*
- Experimental/Investigational, as determined by the carriers, drugs, medicines, treatments or procedures
- Extracorporeal shock wave therapy involving the musculoskeletal system
- Eye movement therapy.
- Eye refractive procedures including radial keratotomy, laser procedures, and other techniques*
- Eyeglasses (Corrective) or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Group Subscriber Agreement (GSA)*
- Foot care (routine), except as provided in the Group Subscriber Agreement (GSA)
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided
- Gloves, unless part of a wound treatment kit
- Hair-loss (or baldness) treatments, medications, supplies and devices including wigs, and special brushes
- Halfway houses
- Hearing aids and the evaluation for the fitting of hearing aids
- Home sleep studies
- Hospice benefits are not available for the following services: food, housing and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those covered under durable medical equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling
- Hypnotherapy except as part of anesthesia preparation or chronic pain
- Infant formula
- In-vitro, GIFT and ZIFT fertilization
- Lay midwife - Services of a lay midwife or an unlicensed midwife
- Malocclusion treatment, if part of routine dental care and orthodontics
- Massage therapy, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program
- Medical and hospital services of a donor when the recipient of an organ transplant is a not a member or when the transplant procedure is not covered
- New medications for which the determination of criteria for coverage has not yet been established by the carrier
- Nutritional supplements except as provided in the Group Subscriber Agreement (GSA)*
- Organ transplants (Non-human), except for porcine (pig) heart valve
- Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures*
- Orthodontic appliances and orthodontic treatment, crowns, bridges, and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related*
- Orthopedic or corrective shoes, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant neuropathies
- Orthotics (functional foot), except as provided in the Group Subscriber Agreement (GSA) for patients with diabetes or other significant peripheral neuropathies
- Orthotics/orthosis (Custom Fabricated) except as specified in the Group Subscriber Agreement (GSA).
- Over-The-Counter (OTC) medications except as specified in the Group Subscriber Agreement (GSA).
- Personal or comfort items, services or treatments
- Photophoresis for all conditions other than mycosis fungoides
- Physical examinations, vaccinations, drugs and immunizations for the primary intent of medical research or non-medically necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment
- Prescription drugs received upon hospital discharge, provided by a hospital pharmacy unless a participating outpatient pharmacy is not available*
- Prescription drugs requiring a benefit certification when benefit certification was not obtained*
- Prescription drugs ordered by a non-participating provider or purchased at a non-participating pharmacy unless required due to an emergency occurring outside of the service area*
- Prescription drug, compounded medications*
- Prescription drug replacements due to loss, theft, or destruction*
- Private duty nursing
- Psychological testing when not medically necessary
- Residential treatment centers unless for the treatment of alcoholism and/or substance abuse rehabilitation
- Reversals of voluntary sterilization - male or female
- Services for which the member is eligible under any governmental program (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the member or dependent
- Services requiring benefits certification when benefit certification was not obtained
- Sex transformation surgery and drugs relating to sex transformation
- Sexual dysfunction treatment, including medication, counseling, and clinics, except for penile prosthesis as provided in the Group Subscriber Agreement (GSA)
- Special education, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the Group Subscriber Agreement (GSA) for more information
- Special medical foods, except as listed as covered in the Group Subscriber Agreement (GSA) for Genetic Inborn Errors of Metabolism
- Storage or banking of sperm, ova (human eggs), embryos, zygotes, or other human tissue
- "Telephone visits and electronic mail (E-mail)" by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient
- Transportation costs for deceased members
- Travel and lodging expense, except as provided in the Group Subscriber Agreement (GSA)
- Vision care (routine) and eye refractions for determining prescriptions for corrective lenses, except as listed as covered in the Group Subscriber Agreement (GSA)*
- Visual training
- Vocational rehabilitation services and long-term rehabilitation services
- Weight reduction or control treatments, except for medically necessary treatment for morbid obesity*
- Work-related accidents or injuries or occupational illness or disease if the member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists

The following is also not covered by the BCBSNM plan:

- Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear, loss or damage.
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services as noted in the Group Service Agreement (GSA)
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.

The following is also not covered by the Presbyterian Health Plan My Care plan:

- Independent option - The following services are not covered on the out-of-network option: Organ transplants, infertility services, cardiac and pulmonary rehabilitation, covered mediations, prescription drugs, specialty pharmaceuticals and special medical foods.

The above is only a summary, some benefits may have further limitations or exclusions. For a more complete description please refer to each plan's member certificate, schedule of benefits or group subscriber agreement.

Dental Plans

Plan Benefits

Each of the dental plan options provides comprehensive dental coverage for enrolled members. On the next pages you will find a general description of each of the options, followed by a Benefits-At-A-Glance chart comparing key benefits of the plans.

In choosing a dental plan it is important to consider the types of services covered and the dental providers available to you. Benefits are based on four main classifications of services:

- **Diagnostic and Preventive** usually includes: cleanings, exams, X-rays, sealants and fluoride treatments
- **Basic** usually includes: fillings, root canals, periodontics, extractions, oral surgery and general anesthesia
- **Major** usually includes: crowns, bridges and dentures
- **Orthodontics** usually includes: diagnostic and retention treatment

Keep in mind this information is a summary only, and you should refer to each plan's official Summary Plan Description for full details, including all limitations and exclusions.

Learn More

You can find more information at **http://eweb.cabq.gov/**

Your Choices

You may choose to enroll yourself and your eligible dependents in one of two dental options:

- Delta Dental Plan of New Mexico
- United Concordia Flex

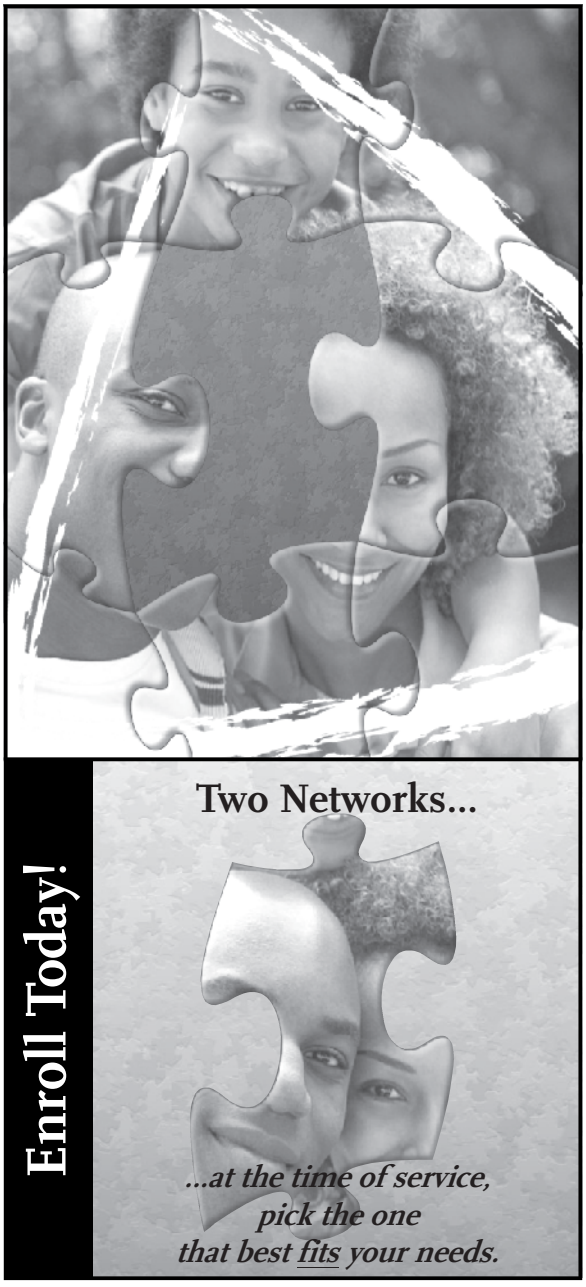
Cost of Coverage

No matter which plan you choose, your employer will pay a portion of the premium. The chart below shows your portion of the cost, which is taken on a per pay period basis. As you can see, your cost depends on the plan you choose as well as what family members you enroll.

	Bi-Weekly (26 Pay Periods) Contributions			
	Delta Dental Plan		United Concordia Flex Plan	
	Employee	Employer	Employee	Employer
Employee only	$2.36	$11.51	$2.27	$11.10
Employee and spouse	$4.71	$23.01	$4.86	$23.73
Employee and children	$4.89	$23.89	$5.02	$24.52
Employee and family	$6.59	$32.18	$6.77	$33.07

DELTA DENTAL®

City of Albuquerque and Participating Entities



By offering two networks, Delta Dental provides enrollees with more choice!

Choose a Delta Dental PPO dentist anytime you want to make sure your share of the cost of a procedure is as low as possible.

Choose a Delta Dental Premier dentist when you need Specialty care not available in Delta Dental PPO, or if you prefer a dentist who only participates in that network.

Both sides of the Delta Dental Point-of-Service plan feature national dental provider networks, with dentists in every state. This plan is all about choice, and a different network selection may be made each time treatment is desired. Pre-selection of a dentist is never required and every member of the family may use a different dentist.

DELTA DENTAL PPO

Delta Dental PPO dentists have specifically agreed to reduced Maximum Approved Fees which result in lower charges for dental services. The dollar amount resulting from the patient co-payment percentage will be less when one of these dentists is selected.

DELTA DENTAL PREMIER

Because the Delta Dental PPO network does not include specialty dentists in every category, and because many enrollees already have established relationships with their dentists, Delta Dental Premier dentists may also be selected for any service. Delta Dental Premier is the nation's most extensive dental network.

BENEFIT ENHANCEMENT

Beginning July 1, 2009, Preventive Care Security (PCS) will automatically be included when you select Delta Dental. With PCS, Diagnostic & Preventive Services are "locked in" and never reduce the Annual Plan Maximum. So even if more costly procedures are anticipated and the full plan maximum will be utilized, we've got you covered! With Delta Dental, it's now even easier to make getting, and keeping, good oral health easy and affordable.

Delta Dental PPO℠	Delta Dental Premier®
• Over 575 points of access in the New Mexico • Over 116,500 dentist locations nationally, with dentists in all 50 states. • Features a fee schedule that helps make dental services more affordable and reduces out-of-pocket costs at the time services are received. • Preventive care covered at 100% when a Delta Dental PPO dentist is selected.	• The broadest selection of dentists – over 370 points of access in the Albuquerque Metro area. • With almost 195,000 dentist locations nationally, and dentists in all 50 states, Delta Dental Premier is the nation's most extensive dental network. Featuring over 930 Points of Access around the state, more than 90% of the dentists in New Mexico participate in Delta Dental Premier.

Use Participating Providers! Out-of-pocket costs will be typically be much lower if services are received from a dentist who participates in one of Delta Dental's provider networks. Maximum Approved Fees are greatly reduced for out-of-network services, and non-participating dentists may balance bill patients up to the full amount of their submitted charges.

2500 Louisiana Blvd NE Suite 600, Albuquerque, NM 87110 (505) 855-7111 or toll free (877) 395-9420 www.deltadentalnm.com

Good news on your United Concordia dental plan…

Valuable New Benefit Feature for 2009!

United Concordia is pleased to announce that ***Preventive Incentive***℠, a valuable new benefit feature, has been added to the ***Concordia Flex***® dental plan for the City of Albuquerque.

With ***Preventive Incentive***, any benefit dollars paid for covered Diagnostic and Preventive services do **not** reduce your annual maximum. Therefore, you will have more benefit dollars available for other covered dental services you may need. Services that qualify for the ***Preventive Incentive*** feature include:

- **Cleanings**
- **X-rays**
- **Emergency treatment for the relief of pain**
- **Exams**
- **Fluoride treatments for dependent children**
- **Sealants for dependent children**

Benefits of Choosing a United Concordia Network Dentist

Through ***Concordia Flex*** you have access to the Advantage *Plus* network of dentists and dental specialists. With nearly 130,000 dentist locations nationwide and 856 locations in New Mexico, we have network dentists available near where you live and work. While you can visit any dentist or specialist without a referral, you will maximize your benefits by visiting an Advantage *Plus* network dentist.

How? By visiting a network dentist…

- **You save money**—Because our network dentists accept our negotiated fees, or maximum allowable charges (MACs), as payment-in-full for covered services, there's no balance-billing and you save more out-of-pocket.
- **You save time**—Our network dentists agree to file claims, so it's one less thing for you to worry about.

To find an Advantage *Plus* network dentist, just visit our website at www.unitedconcordia.com and click on *Find a Dentist*.

Preventive Incentive℠

More Benefits. More Smiles. Now.

United Concordia is the *only* dental plan offering:

- **Orthodontic benefits paid at 60%, up to $1,500**
- **$2,000 per person annual maximum**

CAD-0409

Dental Benefits At-A-Glance

This is a highlight of the benefits only. Refer to your member certificate or group subscriber agreement for specific details, including limitations and exclusions.

	Delta Dental of New Mexico	
	Delta Dental PPO	**Delta Dental Premier**
Annual Benefit Maximum (per plan year) NEW in 2009 PCS Preventive Care Security (PCS) included. Benefits paid for Diagnostic and Preventive Services *never* reduce the Annual Benefit Maximum	$1,500 per person	
Deductible	$50 per person, $150 family (lifetime max)	
Lifetime Orthodontic Benefit Maximum	$1,200 per person	
Diagnostic and Preventive Services		
Examples of Diagnostic and Preventive Services include: Cleanings, Exams, X-rays, Fluoride treatment, Sealants, Emergency treatment for the relief of pain	Plan pays 100% no deductible applies	Plan pays 80% no deductible applies
Basic Services		
Examples of Basic Services include: Fillings, Stainless steel crowns, Root canals, Periodontics, Oral surgery, Prescription medications for dental related conditions	Plan pays 85% subject to deductible	Plan pays 85% subject to deductible
Major Services		
Examples of Major Services include: Specified implant services, Crowns, Partial or complete dentures, Bridges	Plan pays 50% subject to deductible	Plan pays 50% subject to deductible
Orthodontic Services		
Diagnostic, active and retention treatment for adults and children	Plan pays 50%	Plan pays 50%

The benefit levels shown are subject to the applicable Delta Dental Maximum Approved Fees, which are less for Delta Dental PPO dentists than Delta Dental Premier dentists. Because the cost of dental care is less when treatment is received from a Delta Dental PPO dentist, receiving services from these dentists, whenever possible, will result in lower out-of-pocket costs.

Out-of-pocket costs may be significantly higher if services are received from a dentist who does not participate in one of Delta Dental's provider networks. Maximum Approved Fees are greatly reduced for out-of-network services, and non-participating dentists may balance patients up to the full amount of their submitted charges.

Enrolled persons are entitled to a PRE-DETERMINATION OF BENEFITS anytime more costly procedures are anticipated. When requested by a dental provider, an advance estimate of benefits payable can be provided by Delta Dental before dental care services are received. Pre-determination is strongly recommended and there is no charge for this service.

	United Concordia
	Advantage Plus Network
Annual Benefit Maximum (per plan year) NEW FOR 2009 **Preventive Incentive**[SM] included: Benefit dollars paid for covered Diagnostic and Preventive services **do not** reduce your Annual Benefit Maximum.	**$2,000 per person**
Deductible	$50 individual, $150 family (lifetime max)
Lifetime Orthodontic Benefit Maximum	**$1,500 per person**[1]
Diagnostic and Preventive Services	
Examples of Diagnostic and Preventive Services include: Cleanings, Exams, X-rays, Fluoride treatment, Sealants, Emergency treatment for the relief of pain	Plan pays 100% of allowable amount, no deductible applies[2]
Basic Services	
Examples of Basic Services include: Fillings, Stainless steel crowns, Root canals, Periodontics, Oral surgery, Prescription medications for dental related conditions	Plan pays 85% of allowable amount after deductible[3]
Major Services	
Examples of Major Services include: Specified implant services, Crowns, Partial or complete dentures, Bridges	Plan pays 50% of allowable amount after deductible
Orthodontic Services	
Diagnostic, active and retention treatment for adults and children	**Plan pays 60% up to lifetime maximum**

1. Only applies to new treatment plans begun on or after July 1, 2007.
2. Flouride: 2 per year up to age 19. Sealants: permanent molars only.
3. Amalgam fillings on posterior teeth. Composite resin fillings for anterior teeth only.

Benefit percentages shown above are based on the in-network contracted fees or dentist's charge, whichever is less. Additional out-of-pocket cost may apply to non-network dentists.

DAVIS VISION®
THE EYECARE ADVANTAGE

The Importance of Annual Eye Examinations

Did you know that a Dilated Fundus Evaluation can detect up to 30 systemic diseases? That's right... in addition to ensuring proper eyesight, regular eye examinations allow doctors to detect and treat diseases at the earliest possible opportunity. The eyes are the window into the entire body, and a comprehensive eye examination can be as important for your overall health, as it is, for ocular health. An eye examination that includes dilation (Dilated Fundus Evaluation) can uncover signs of hypertension, AIDS, arteriosclerosis, diabetes, Graves' disease, stroke, high cholesterol and many other conditions, as well as common eye disorders.

Annual comprehensive eye examinations are of vital importance in preventing and/or delaying eye disease for those at higher risk for eye disease, such as those over age 65, people with diabetes and African Americans over age 40.

Children's Eye Examinations

Visual disorders can be detected in children as young as six months. Eye examinations for infants, preschoolers and school-age children can protect against vision-threatening disorders. The American Public Health Association recently issued an official policy resolution urging regular eye examinations for all children. Treatment for visual development or eye health problems will be most effective when introduced at the earliest stages. Ideally, well-child eye examinations should begin at age three and be scheduled regularly thereafter to ensure there is no evidence of eye disease.

Vision Impacts Learning

Children under 12 learn by visual cues. In the first 12 years, 80% of all learning takes place visually. Visual impairment can significantly handicap a child's intellectual and emotional growth, as well as social development. Vision problems affect one in four children between the ages of five and 12. Many parents rely on vision screenings offered in schools or by pediatricians to detect vision concerns, but these screenings are not through. They can detect vision problems in only 20%-30% of children, and may not expose problems of eye muscle coordination, eye disease, peripheral vision or shortcomings in near/distance vision. A thorough eye examination should be provided.

Healthy eyes... healthy lives!

Vision Plan

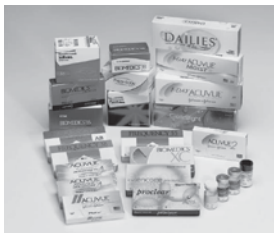
Employees are offered vision care benefits through Davis Vision. Remember routine eye examinations are not offered through the medical plans.

Davis Vision Plan Benefits

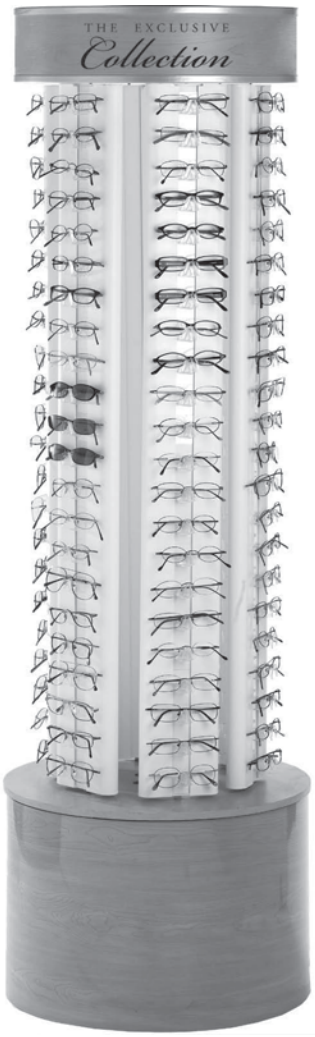
The Vision Plan offers coverage for general vision benefits such as eye examinations, eyeglasses and contact lenses throughout the state. Providers represent all types of vision specialists, including: private optometrists, ophthalmologists, free-standing retail stores and optical centers located within national retail department stores. Call 1-800-999-5431 to find a network provider near you or access the directory online at www.davisvision.com.

A description of coverages is listed below. Keep in mind that this information is a summary only, and you should refer to the plan's official Summary Plan Description for full details, including all limitations and exclusions.

Service	Frequency	In-Network Coverages	Out-of-Network Reimbursement[1/]
Eye Examination (includes Dilated Fundus Evaluation)	Every 12 Months	Covered in full after $10 copayment	up to $35
Spectacle Lenses	Every 12 Months	Covered in full after $15 copayment	up to:
Single-vision			$25
Bifocal			$40
Trifocal			$55
Lenticular			$80
Frames	Every 24 Months	Premier Collection frame covered in full after $15 copayment, OR $40 wholesale frame allowance (equivalent to $80 - $120 retail value) toward any non-Collection frame	up to $35
Contact Lenses (in lieu of eyeglasses)	Every 12 Months	Formulary Lenses covered in full, OR $110 allowance, plus 15% discount off any overage toward non-Formulary lenses	up to $110
Medically necessary (prior approval required)		Covered in full	up to $210



Contact Lens Formulary



Exclusive Frame Collection

[1/] To request claim forms, visit www.davisvision.com or call 1-800-999-5431. Completed claim forms should be sent to Davis Vision directly for reimbursement. Send to: Vision Care Processing Unit, P.O. Box 1525, Latham, N.Y. 12110.

Cost of Coverage

When you enroll in the vision plan, you are responsible for part of the premium cost, which is taken on a per-pay-period basis. As shown, the amount depends on which family members you enroll.

	Bi-Weekly (26 Pay Periods) Contributions	
	Employee	**Employer**
Employee only	$0.39	$1.92
Employee and spouse	$0.74	$3.62
Employee and children	$0.79	$3.83
Employee and family	$1.18	$5.75

As a safeguard to protect the utilization of the Vision Plan, City of Albuquerque and participating entities have a 2-year enrollment requirement under this plan. You and each member of your family have to fulfill the 2-year enrollment requirement before you can drop vision coverage.

Basic Life and AD&D Insurance

If you are an eligible permanent full-time or part-time employee, you are covered by the CIGNA basic life and accidental death and dismemberment (AD&D) plan. The City provides this coverage at no cost to you.

Basic Life Benefit
If you die, the plan will pay your designated beneficiary a benefit of 1.4 times your basic yearly compensation, rounded to the next higher $1,000. Regardless of the amount of your basic yearly compensation, the benefit will not be less than $25,000 or greater than $50,000.

When you retire, your coverage will reduce by 50%. Your employer will continue to provide this coverage at no cost to you. You may convert the lost coverage as outlined below.

Converting Your Coverage
When your coverage is reduced or ends (for any reason except nonpayment of premiums) you can convert the lost coverage to an individual permanent life insurance policy. No medical certification is needed. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after group coverage ends. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed.

Accident Insurance Benefit
The plan will also pay benefits for losses due to covered accidents. A covered accident is a sudden unforeseeable event that results in injury or death and that occurs while coverage is in force. The AD&D benefit amount is the same as the Basic Life benefit amount. The full benefit will be paid in the event of accidental loss of life occurring within 365 days of a covered accident. Or, to help survivors of severe accidents adjust to new living circumstances, a percentage of the benefits will be paid for dismemberment and/or loss of eyesight.

Waiver of Premium
If you become totally disabled – To make sure you can keep the life insurance protecting you during a difficult period of your life, this plan provides a waiver of premium feature. If you submit proof that you became totally disabled prior to age 60 and have remained continuously totally disabled at least 9 months, your coverage will continue until age 65, subject to proof of continuing disability each year. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness.

Will Preparation Program
When you are covered by CIGNA life insurance, CIGNA's Will Center makes it easy for you to take charge of difficult life and health legal decisions. There are no more reasons to hesitate planning for the future with the online will preparation service. You can easily complete essential life and health legal documents online at no cost to you. CIGNA's Will Center is secure, easy to use, and available to you seven days a week, 365 days a year. Go to CIGNAWillCenter.com. To access your Personal Estate Planning web page, simply complete the online form and register as a new user. Once registered, you can immediately start building your will and other legal documents.

CIGNA®
A Business of Caring.

Learn More

To learn more, call 505-768-3758.

Help.

A good job, a hard day's work are the threads from which pride and self-respect are woven. Should a disabling accident or illness cut those threads, planning ahead can make an enormous difference. We focus on making sure people are prepared. And use some innovative ways to help them get back on their feet faster. We've found that when you remind people how much fun life is, they can't wait to be a part of it.

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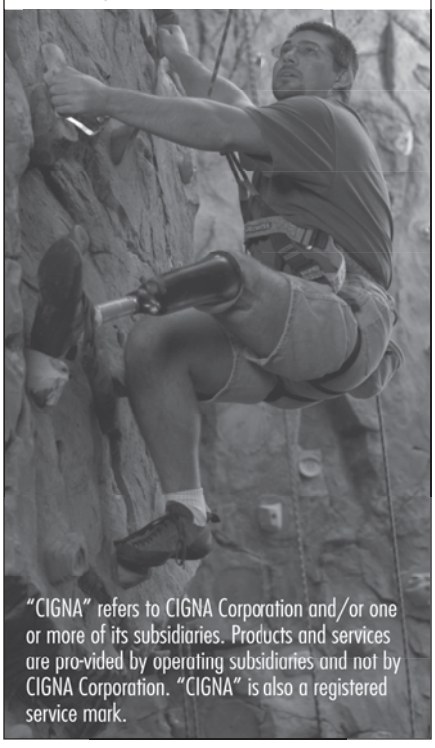

Voluntary Life Insurance

If you would like to purchase additional life insurance protection for you or your dependents, you may do so through CIGNA's voluntary life insurance. You must be a full-time employee and work a minimum of 20 hours per week to be eligible. This plan is a voluntary plan, meaning if you participate you are responsible for the entire cost of the premium.

Voluntary Coverage for Yourself

You can buy coverage for yourself in increments of $10,000 up to $500,000. If you purchase an amount greater than $250,000 or increase coverage after initial eligibility, you will need to provide evidence of insurability. Death benefits will be reduced by 50% at age 70. And, your coverage ends when you retire. Reduced or terminated coverage may be converted to an individual permanent life insurance policy. Please refer to your Group Insurance Certificate, or to the conversion brochure available from Human Resources, for details.

If you become totally disabled before turning 60 years old, your coverage will remain in force without needing to pay premiums provided the insurance company approves you for this waiver of premium benefit. There is a nine-month waiting period and benefits will continue to age 65, as long as you remain totally disabled and provide proof each year. If you become terminally ill, you may receive 50% of your death benefit up to $250,000.

When you enroll in the voluntary life plan, you pay the premium cost through payroll deductions. The chart to the right shows your cost depending on your age and whether or not you smoke. You are considered a smoker if you used any form of tobacco in the last 12 months. Deductions are taken on a per pay period basis.

A sample contribution calculation

Employee *(age 28, non-smoker)*	*$250,000 ÷ 10,000 = 25 units* 25 units X $0.215 per unit	=	$5.38
Spouse/Domestic Partner *(age 24, smoker)*	$100,000 ÷ 10,000 = 10 units 10 units X $0.443 per unit	=	$4.43
Children	$10,000 benefit level **Total Bi-weekly Cost**	=	$0.96 **$10.77**

Additional AD&D Coverage

When you and/or your spouse/domestic partner enroll in voluntary life insurance you automatically receive additional AD&D coverage of $20,000.

Rate Per $10,000

Age	Smoker Rate	Non-Smoker Rate
Less than 30	$0.443	$0.215
30-34	$0.550	$0.275
35-39	$0.882	$0.443
40-44	$1.218	$0.658
45-49	$2.258	$1.271
50-54	$3.381	$1.880
55-59	$4.925	$2.709
60-64	$6.248	$3.486
65-69	$9.230	$5.198
70-74	$17.577	$9.786
75-79	$27.290	$15.194
80 and older	$65.573	$36.572

Voluntary Coverage for Your Dependents

If your spouse/domestic partner or child is also an employee of the same employer, they may only be covered as an employee or a dependent. No one may be covered as both an employee and spouse/domestic partner or employee and child.

If you decide to purchase coverage for your spouse/domestic partner, you may purchase coverage in increments of $10,000 up to $500,000, whether or not you purchase coverage for yourself. Rates are based on age and whether or not your spouse/domestic partner smokes. They are considered a smoker if they used any form of tobacco in the last 12 months. If you purchase an amount of dependent life coverage greater than the coverage amounts in the table to the right or increase coverage after initial eligibility, evidence of insurability will apply, which means you need to supply proof of good health which is acceptable to the insurance company.

Employee Coverage Amount	Spouse/Domestic Partner Coverage Guaranteed Amount
$50,000	$10,000
$100,000	$20,000
$150,000	$30,000
$200,000	$40,000
$250,000	$50,000

You can also enroll your children in the plan. Coverage starts for children at least 14 days old through age 25. You can purchase coverage in increments of $2,500 to a maximum of $10,000. Coverage is limited to $500 for children 14 days to six months old. You and/or your spouse/domestic partner must be enrolled to enroll your dependent children.

Child Coverage Amount	Rate
$2,500	$0.240
$5,000	$0.480
$7,500	$0.720
$10,000	$0.960

Guarantee issue is available only at initial eligibility. All other requests for coverage are subject to underwriting approval. Rates for age 75 and over apply to active, full-time employees only. Spouse/domestic partner coverage ends at age 75. Suicide is excluded for the first two years of voluntary life coverage. Exclusions for the AD&D coverage will be listed in the enrollment brochures. This is a summary of group term life insurance coverage available under CIGNA Group Insurance. For specific provisions, please contact the City of Albuquerque Insurance Office (505-768-3758). Underwritten by Life Insurance Company of North America. This information is a brief description of the important features of the plan. It is not a contract. In the event of a discrepancy between this summary and the group insurance policy, benefits will be paid according to the terms and conditions of the policy. Please refer to your Life Insurance Company of North America brochure for a complete description of benefits, limitations and exclusions.

Long-Term Disability Coverage

The long-term disability (LTD) plan pays benefits if you become disabled for an extended period of time. If you are a full-time employee and you work a minimum of 20 hours per week, you may purchase LTD insurance through CIGNA. This plan is a voluntary plan, meaning if you participate you are responsible for the entire cost of the premium.

Your Age	Cost Per Dollar of Bi-weekly Payroll
Less than 20	$0.00262
20-24	$0.00262
25-29	$0.00262
30-34	$0.00406
35-39	$0.00406
40-44	$0.00536
45-49	$0.00770
50-54	$0.01004
55-59	$0.01199
60-64	$0.01238
65 and older	$0.01238

A sample contribution calculation

Your salary = $32,000 at age 32

$32,000 divided by 26 pay periods = $1,231

$1,231 multiplied by $0.00406 (rate) = $5.00 per paycheck

Bi-weekly salary maximum is $3,846.

The LTD benefit provides you with income when you are unable to work for at least 90 days. You must be disabled as a result of a covered injury or sickness, and you must be under the appropriate care of a licensed, practicing physician who is qualified to treat your disability. Once you have been approved by CIGNA and disabled for 90 days of continuous disability, you will begin to receive disability benefits up to 60% of your eligible prior pay not to exceed $5,000 of benefits per month. (The minimum monthly benefit is $50.) The maximum amount may be reduced if you are receiving other sources of disability income from programs such as:

- Workers' compensation
- Social Security
- Another group disability or State disability plan
- A retirement plan, including PERA sponsored by your employer
- A dependent's coverage in which benefits are payable due to a covered person's disability
- Other government plans

If you are diagnosed with mental illness, drug or alcoholism benefits are limited to a 24-month lifetime maximum.

If you die while receiving benefits from the plan, a three-month sum will be paid to your beneficiary.

This plan contains a pre-existing limitation. This means that if you received medical treatment within three months before your coverage becomes effective, the plan will not pay benefits for a disability related to that condition. This limitation does not apply to a disability that begins after you are covered for at least 12 months after your coverage takes effect.

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Definition of Disability

In order to receive benefits, you must be considered disabled under the plan, which generally means:

- **For the first 24 months of your disability,** you are not able to perform the duties of your own occupation and you are unable to earn more than 80% of your prior income.
- **After 24 months of disability,** you are not able to perform the duties of any occupation and you are unable to earn more than 60% of your prior income.

See the plan document for details, including limitations and exclusions.

Underwritten by Life Insurance Company of North America. A list of exclusions and limitations is included in the enrollment brochure. This information is a brief description of the important features of the plan. It is not a contract. In the event of a discrepancy between this summary and the group insurance policy, benefits will be paid according to the terms and conditions of the policy. Please refer to your Life Insurance Company of North America brochure for a complete description of benefits, limitations and exclusions.

Flexible Spending Accounts

You may choose to participate in one or both of the flexible spending accounts:

- Medical Care Reimbursement Account
- Dependent Care Reimbursement Account

These accounts are administered by BASIC, who holds your payroll deductions and makes reimbursements to you out of your account(s). You must complete the Flexible Benefit Plan Election/Change Form and the Direct Deposit Authorization Form (located on the back of the enrollment form) to participate.

The medical care reimbursement account lets you set aside tax-free-dollars for a wide range of health-related expenses that are not covered by the medical, dental or vision plans. You do not have to enroll in the medical, dental or vision plans to participate in this program.

The dependent care reimbursement account lets you set aside tax-free dollars for eligible day care expenses for your dependents.

For expenses to qualify:

- You and your spouse must be employed or actively seeking employment or attending school full time.
- Dependent care provider must claim payments as income.
- Dependent care expenses paid during a sick leave, holiday, or vacation are not eligible.
- Expenses must be for the care of a qualified person:
  - A child under 13 years old who is a dependent for income tax purposes. (If your child turns 13 during the plan year, expenses are no longer eligible for reimbursement.)
  - A spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day in your home (i.e. an invalid parent). The same rules that apply for child care apply to the care of other dependents, except that the dependent need not be under age 13.

How the Accounts Work

First, you must incur an eligible expense. Then, you submit a Reimbursement Form and receipts to BASIC. You will receive the reimbursement through direct deposit if you complete the Direct Deposit Authorization Form. Since you are reimbursing yourself with "tax-free" dollars, you have more buying power than if you paid for the same expenses with after-tax dollars.

When you enroll, you need to decide how much you would like to contribute to your accounts each year:

- **For the medical care account,** the plan minimum is $260 (or $10 per pay check) and the maximum is $5,000 per eligible employee per year. If you and your spouse are employed by the City each can contribute $5,000.
- **For the dependent care account,** the plan minimum is $260 (or $10 per pay check) and the maximum is $5,000 (married-filing jointly) or $2,500 (married-filing separately) each year.

You must carefully consider how much you would like to contribute. Because of the tax break, the IRS requires a "use it or lose it" feature for this benefit. That means if you have not incurred enough qualified expenses by the end of the plan year, it will be forfeited. The $4.50 fee per participant per month will be paid by the City.

You must enroll each year if you want to continue participating in the flexible spending account program.

BASIC WESTERN USA

Learn More

You can find more information at **http://eweb.cabq.gov/**

www.basiconline.com

The dependent care account is a pay-as-you-go account. You may only be reimbursed up to the amount you have contributed to the account.

You should check with a tax advisor to see what your savings might be if you participate in the flexible spending account program.

Note that you are unable to use certain tax credits if you use the FSA accounts.

Federal regulations do not permit expenses for domestic partners to qualify for the flexible spending accounts.

This is an example of how you can save tax dollars with an FSA.

	With FSA	Without FSA
Annual income	$40,000	$40,000
Estimated health care expense	$3,500	$0
Taxable income	$36,500	$40,000
Estimated federal tax	$5,475	$6,000
Estimated Social Security tax	$2,792	$3,060
Healthcare expenses	$0	$3,500
Net pay	$28,233	$27,440
Savings with FSA	$793	N/A

Eligible FSA medical expenses include:

- Ambulance service
- Birth control
- Copays and deductibles
- Crutches
- Eye glasses
- Nursing care
- Medically prescribed physical therapy
- Orthodontics[1]
- Over-the-counter medicines such as pain relievers, antacids, allergy medicines and cold medicines[2]
- Smoking cessation programs, nicotine patches, and nicotine gum
- Special Needs[3]

For a comprehensive list of eligible expenses, visit www.irs.gov and search for IRS Publication No. 502.

Eligible FSA dependent care expenses include:[4]

- The costs for dependent day care, at home or in a day care center
- Nursery school expenses

For more information, visit www.irs.gov and search for IRS Publication No. 503.

Debit Card Option

Participants in the Flex Medical and/or the Flex Dependent Care plan may elect to receive a debit card. This can be used like a credit card to purchase qualified items or services, such as office visit and prescription drug copays. This option is an alternative to paying out of pocket and being reimbursed by the plan. This includes being able to purchase over-the-counter medical items such as cold medicine. A form separate from the plan enrollment form is required to apply for the debit card for yourself, spouse and any qualified dependents over age 18.

Examples of ***ineligible health care expenses*** include Retin-A, weight loss programs, health club dues, diaper service, long-term care expenses.

Examples of ***ineligible dependent care expenses*** include transportation expenses, convalescent or nursing home expenses and overnight camp expenses.

Parking and Transit Plan (Section 132 Plan)

Now you can also save money on your transit costs (up to 40%) by joining the parking and transit program administered by BASIC.

You can pay for your work-related parking and mass transit costs with tax-free dollars. Because the City pays the administration fee, there is no cost to participate in this program.

How Much You Can Allocate Tax-Free?

The calendar year limit for mass transit is $230 per month and $230 per month for parking.

Any unused funds continue to roll over month-to-month, year-to-year as long as you are an active employee. Requests for reimbursement must be made within six months of the pre-tax contribution.

Enrolling

City-Owned Lots:

You must contact the Parking Division of the Municipal Development Department at 924-3950. By enrolling through them, your monthly salary reduction will automatically be applied to your payment due for parking.

Non-City Lots:

You must enroll online at www.basiconline.com Click on BASIC Parking. Click on submit expenses to complete the enrollment form.

To receive reimbursement for non-City lot parking, expenses must be submitted online at www.basiconline.com. You will receive your reimbursement by direct deposit only.

What Expenses Are Eligible

Your parking expenses on or near the premises of the City of Albuquerque or a location from which you commute to work by train, bus, van or carpool.

Parking/transit expenses resulting from travel to or from meetings, to visit other City departments, or other locations are ineligible for reimbursement.

[1]Reimbursement can only be made in accordance with the orthodontia contract, (e.g., monthly quarterly, etc). The orthodontia contract must be provided with each claim.

[2]These items must be purchased to alleviate or treat personal injury or sickness. Eligible items do not require a prescription. If the cash register receipt does not show the item description, a copy of the product packaging with price tag will be needed with the receipt.

[3]The service must be prescribed by a physician to treat a medical condition. Treatment cannot be for general health and/or well being.

[4]The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (i.e. an older child).

- If the services are provided by a day care facility, that facility must comply with state day care regulations.
- Services must be for the physical care of the dependent, not for education, meals, registration, etc.
- Overnight camps and lessons in lieu of day care are not eligible for reimbursement from a dependent care account.

Supplemental Retirement Plans

Your 457 Deferred Compensation Program

Deferred Compensation seeks to provide **"Extra"** money you need for a more enjoyable and comfortable retirement lifestyle.

What is Deferred Compensation?

- Voluntary, IRS-approved retirement savings plan
- Pre-Tax and Tax Deferred – build retirement savings for tomorrow and reduce today's taxes (income taxes are due in the year in which the money is withdrawn usually during retirement when you are in a lower tax bracket)
- Under Section 457 of the IRS, you may defer each year a maximum of 100% of your "gross compensation" or an annual dollar limit, whichever is less. The dollar limit for 2009 is $16,500
- Contributions are conveniently made through payroll deductions so your taxes are reduced each pay period
- Plans allow you to increase, decrease, stop and restart contributions as often as you wish, without fees or penalties

Benefits of Deferred Compensation

- Reduce current income taxes while investing for retirement
- Earnings accumulate tax-deferred
- Dollar cost average through convenient payroll deduction
- 50 or older or within 3 years of normal retirement age you are allowed to make additional "catch-up" contributions
- It's portable – if you change jobs you can consolidate your savings in another public sector employer's 457 plan, a qualified 401 plan, a tax sheltered 403b annuity plan, or traditional IRA
- If you retire or leave service early, there is no penalty for withdrawal
- Supplemental investments are helpful for those employees where no contribution is made to social security
- Deferred compensation accounts can be used to purchase withdrawn service, military service and air time with PERA

Contact your Plan Representative for more information.

Your Benefits Department offers these Deferred Compensation Providers:

ICMA RC

Building Retirement Security

Representative:	**Steve Lopez**
Telephone:	(505) 842-8610
Toll Free:	(800) 669-7400
Email:	slopez@icmarc.org

Representative:	**Dennis Dexel**
Telephone:	(505) 899-5011
Email:	ddexel@icmarc.org

VALIC

RETIREMENT SERVICES

Representative:	**Jeremy Mitchell, CFP©**
Mobile:	(505) 263-4180
Toll Free:	(800) 892-5558 x87607
Email:	jeremy.mitchell@aigretirement.com

Securities and investment advisory services are offered by AIG Retirement Advisors, Inc., member FIRNA, SPIC and an SEC-registered investment advisor.

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Representative:	**Linda Miller**
Telephone:	(505) 989-4992
Toll Free Tel:	(866) 827-6639 ext 44415
Fax:	(505) 989-4991
Email:	millel45@nationwide.com
Website:	www.newmexico457dc.com

Start saving for retirement now rather than later…

For example: One employee began a deferred compensation account at age 30 and saved $2,000 per year for ten years ($20,000.) Averaging an 8% rate of return, at age 65 she had accumulated $198,422.

However, another employee did not begin a deferred compensation account until age 40, saving $2,000 ever year for 25 years ($50,000.) With the same 8% return, the total was $157,909 at age 65. Waiting to begin made a difference of over $40,000 in earnings and $30,000 in employee contributions.

Remember that investments don't grow at an even rate of return and may even lose value.

Contact a representative today to learn more!

Contacts and Resources

Employer

Offices	Contact Numbers
City of Albuquerque Insurance and Benefits Office 400 Marquette NW, Room 702 PO Box 1293 Albuquerque, NM 87103	(505) 768-3758 phone (505) 768-3760 fax
Public Employees Retirement Association (PERA) Albuquerque Office – 2500 Louisiana Blvd NE, Suite 420 www.pera.state.nm.us	(505) 883-4503 phone (505) 883-4573 Santa Fe (800)342-3422 toll free
New Mexico Retiree Health Care Authority Albuquerque Office – 4308 Carlisle Blvd, NE, Suite 104 www.nmrhca.state.nm.us	(505) 222-6400 phone (800) 233-2576 toll free (505) 884-8611 fax

Core Benefit Vendors

Product	Company Name	Group Number	Customer Service Website Addresses
Medical	Blue Cross Blue Shield of New Mexico (BCBSNM)	N12698-0101	877-232-5538 www.bcbsnm.com
	Presbyterian Health Care	1365-H001	505-923-5678 800-356-2219 www.phs.org
Dental	Delta Dental	2517-0001	505-855-7111 877-395-9420 www.deltadentalnm.com
	United Concordia Dental	844614	800-332-0366 www.ucci.com
Vision	Davis Vision	ABQ001	800-999-5431 www.davisvision.com
Life (Term)	CIGNA Group Insurance	FLX980032 (Basic) FLX980018 (Voluntary)	800-238-2125 www.cigna.com
Long Term Disability	CIGNA Group Insurance	VDT960021-001	800-238-2125 www.cigna.com
Flexible Spending Accounts (Medical, Dependent Care, Parking/ Transit)	Basic Western USA		800-444-1922 ext. 229 - FSA ext. 243 – Parking/Transit www.basiconline.com
Deferred Comp (457)	ICMA-RC	300476	800-669-7400 Cust. Svc. 505-899-5011 Dennis Dexel 505-842-8610 Steve Lopez www.icmarc.org
	Nationwide	007844	505-362-8814 Linda Miller 866-827-6639 ext. 44415 Toll Free Voice Mail www.newmexico457dc.com
	VALIC		505-263-4180 Jeremy Mitchell www.valic.com

Notes

Notes

Human Resources Department
Patricia D. Miller, Director
768-3700

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PRESBYTERIAN Health Plan

CIGNA
A Business of Caring.

UNITED CONCORDIA
America's Premier Dental Insurer

Blue Cross and Blue Shield of New Mexico

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THE EYECARE ADVANTAGE

BASIC
WESTERN USA

DELTA DENTAL

VALIC
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